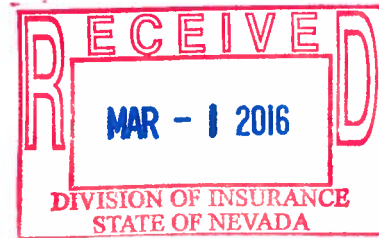




March 1, 2016

Ms. Amy L. Parks, Esq.  
Acting Commissioner, Nevada Division of Insurance  
1818 E. College Pkwy., Suite 103  
Carson City, NV 89706



Re: Regulation R049-14, Network Adequacy

Dear Acting Commissioner Parks:

On behalf of the undersigned organizations, representing nearly 15,000 dermatologists nationwide, we appreciate the opportunity to comment on proposed draft regulations that would establish network adequacy requirements. We support the Nevada Division of Insurance's ("Division") decision to amend the draft proposal of Regulation R049-14 as we continue to have concerns with several sections of the proposal. As such, we request the following amendments:

**Recommendation #1:** Section 9 would define material change as any change that results in a deficiency in the adequacy of the network plan; however, within the definition of "material change," "deficiency" is not defined and could be interpreted too broadly to remedy network inadequacy. Thus, we recommend deleting the existing definition of "material change" and substitute Section 9 with the following language:

A "material change" in a network plan is any change, or combination of changes taking effect within 30 days of each other, that:

- (a) For specialties or categories of health care with more than 10 providers, affects network plan capacity by more than 10 percent in any single specialty or category of health care for which a benefit is offered;
- (b) For specialties or categories of health care with 5 or fewer providers, affects network plan capacity by more than 20 percent in any single specialty or category of health care for which a benefit is offered; or
- (c) A change in network that could cause the coverage to change the actuarial value of a plan, due to a change in benefit design that modifies the recipient's benefits, including but not limited to, physician network or drug coverages.

**Recommendation # 2:** Section 17 would create the nine-member Network Adequacy Advisory Council ("Council"), which would develop and provide recommendations to the Commissioner of Insurance as to the network adequacy requirements for the relevant plan year. The Council would include representatives of carriers, health care providers, and consumers. We recommend the composite of the nine-member Council be required to consist of at least two representatives who are health care providers or their representatives and two representatives of the patient community to ensure all stakeholders are adequately represented.

**Recommendation #3:** Section 19 would require the Council's network adequacy recommendations to include specialties and categories of health care providers that are included on the Centers for Medicare and Medicaid (CMS) Services' Network Adequacy Template. CMS' Network Adequacy Template is very restrictive and does not ensure patients access to a broad range of specialties. For example, dermatology is not among the fourteen provider and facility types included in CMS' template table, thereby restricting patient access to dermatologic care; therefore, we recommend using Medicare Advantage Health Service Delivery (HSD) table in addition to the Network Adequacy Template.

Dermatologists treat a majority of patients who present skin conditions in America, including non-melanoma skin cancer, melanoma, and psoriasis. Utilizing CMS' template table and the HSD table, which includes thirty-one specialty and facility types, will increase patient access to dermatologic and other specialty care.

Additionally, Section 19 would limit the Division's evaluation of provider access primarily to the general specialty for most specialties; however, adequate access to subspecialties should also be ensured where deemed appropriate. Dermatology has several sub-specialties, including Mohs Micrographic Surgery and Pediatric Dermatology, which without adequate access, care could be delayed or deferred, and resulting in higher costs.

Thus, we request the Division consider additional specialty or subspecialty categories of physicians for evaluation based on the needs of the population when determining the requisite categories of providers by amending Section 19 as follows:

- (a) The specialties and categories of health care which:
  - (1) Appear on the Medicare Advantage Health Service Delivery table;  
or
  - (2) ~~(1)~~ Appear on the Network Adequacy Template; and
  - (3) Are offered certification by:
    - a. Member Boards within the American Board of Medical Specialties; or
    - b. The American Osteopathic Association

- or
- (4) Any additional specialty or subspecialty deemed appropriate by the commissioner; or
- (5) ~~(2)~~ Are mandated under Nevada law; and
- (b) Standards which are acceptable to the Center for Medicare and Medicaid Services for qualified health plans.

**Recommendation # 4:** Section 21 would require carriers who apply for the issuance of a network plan to establish that the proposed network plan is adequate; however, the proposal does not include any criteria to establish adequacy. We recommend criterion adopted by the Centers for Medicare and Medicaid Services (CMS) regulations. As such, we recommend including the following language:

1. In determining whether a network plan is adequate, the Commissioner may, but is not limited to, consider:
  - (a) The relative availability of health care providers in the geographic service area covered by the network plan, including, without limitation, the:
    - (1) Operating hours, or their equivalent, of available health care providers; and/or
    - (2) Established patterns of care
  - (b) The ability of a health care provider to enter into a contract with carrier with the travel standards provided pursuant to Section 15 of this regulation;
  - (c) The system for the delivery of care to be furnished by the health care providers contracted by a carrier in the network plan;
  - (d) The availability of health care providers located outside of the network plan's geographic service area but within the travel standards provided pursuant to Section 4 of this regulation;
  - (e) The availability of nonemergency services accessible during normal business hours and medically necessary emergency services accessible at any time;
  - (f) Provider-covered person full-time equivalent ratios by specialty and subspecialty; and
  - (g) The number of providers accepting new patients.

**Recommendation #5:** Finally, we again request that the Division include language that would provide physicians with a meaningful appeal whenever a physician is terminated from a network, regardless of how the plan characterizes the termination. The appeal review should consider whether the removal of the physician from the network would result in network inadequacy, and this should be a basis for

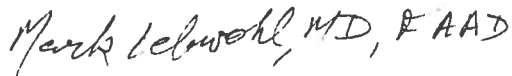
Re: Regulation R049-14, Network Adequacy

reinstatement. Additionally, beneficiaries should always be provided reasonable and adequate notice of physician termination, and should be allowed to stay with a physician until the next open enrollment period if the provider is eliminated "without cause" from a network mid-year.

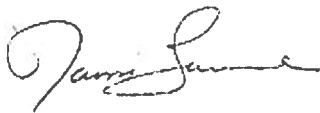
### **Conclusion**

We commend the Nevada Division of Insurance for its effort to ensure the citizens of Nevada have access to needed health care services in a timely fashion and urge the Division to include the proposed amendments described above. Should you have any questions, please contact David W. Brewster, Assistant Director for Practice Advocacy for the American Academy of Dermatology Association at 202-842-3555 or [dbrewster@aad.org](mailto:dbrewster@aad.org).

Sincerely,



Mark Lebwohl, MD, FAAD  
President  
American Academy of Dermatology Association



Naomi Lawrence, MD  
President  
American Society for Dermatologic Surgery Association